Washington State Health Care Authority
Public Employees Benefits Board

Certification of Dependent With a Disability

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- Attach a completed enrollment form along with this form if this is a new enrollment.
- Complete Subscriber and Dependent sections; you must have your doctor complete the Physician section on the back of this form.

To be eligible for enrollment in PEBB coverage after turning age 26, a dependent child must be determined to be incapable of self-support due to a disability which occured before age 26. Depending on your dependent's enrollment status, you will need to provide evidence of your child's eligibility within the timelines below:

1. **If the child is not currently enrolled in PEBB coverage or is the dependent of a newly eligible subscriber**—You must provide evidence that the disability occurred before age 26. You must do this within your enrollment timelines.
2. **If the child is currently enrolled in PEBB coverage**—You must provide evidence of the disability no later than **60 days** after the child turns age 26.

Subscriber Information

Last name	First name	Middle initial	Social security number	
Address	Apt./unit number	City	State	ZIP Code
Mailing address (if different)	Apt./unit number	City	State	ZIP Code
Work phone number ( )	Home phone number ( )	Agency/Subagency		

Dependent Information

Last name	First name	Middle initial	Social security number

❑ New enrollment ❑ Recertification	Is dependent enrolled in Medicare? *(If yes, attach copy of Medicare card or entitlement letter.)*	**Part A** ❑ Yes ❑ No **Part B** ❑ Yes ❑ No
Date of birth (mm/dd/yyyy)	Age when disability occurred	Relationship to subscriber ❑ Son ❑ Daughter ❑ Other _____
Has this dependent ever been employed? ❑ Yes ❑ No		Is this dependent currently employed? ❑ Yes ❑ No
List the employer names and addresses and dates of employment		

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan or premiums paid on my dependent's behalf. My dependent may also lose PEBB benefits as of the last day of the month he or she qualified. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

The PEBB Program will verify eligibility for me and my family members. I understand that the PEBB Program may ask for this verification at any time. However, the PEBB Program will verify the disability and dependency of children with disabilities periodically, but not more frequently than annually after the first two years.

This form replaces all previous *Certification of Dependent With a Disability* forms I have submitted for PEBB benefits.

HCA's Privacy Notice: We will keep your information private as allowed by law. To see our Privacy Notice, call 360-725-0442 or go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

(continued)

Certification of Dependent With a Disability *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Physician: Complete this section *The subscriber must pay any fees for completing this form.*

Physician's last name	First name	Middle initial

Mailing address	City	State	ZIP Code

Is this dependent capable of employment to independently support himself/herself? ❑ Yes ❑ No

If yes, please indicate ❑ Full-time ❑ Part-time If no, please explain why under "Nature of disability" below.

Has disability existed continuously since before age 26? ❑ Yes ❑ No If no, when did disability first exist? _____

Nature of disability, including diagnosis (please give as much detail as possible)

_____

_____

_____

_____

_____

_____

Prognosis (please estimate duration of disability)

_____

_____

_____

_____

_____

_____

I certify that, to the best of my knowledge and belief, the information I have provided is true and accurate.

Physician's signature _____ **Date** _____

Questions? Call the PEBB Program at 1-800-200-1004.

Mail completed form and documentation to:

Washington State Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

or fax to: 360-725-0771